

# Gonorrhea

## 1. DISEASE REPORTING

### A. Purposes of Reporting and Surveillance

1. To assess trends in epidemic patterns, understand the impact of the burden of disease on populations, the health care infrastructure, and to better target population-level disease prevention efforts;
2. To assure the adequate treatment of infected individuals in order to reduce the duration of infectiousness and prevent sequelae of infection. (e.g., PID, ectopic pregnancy, infertility);
3. To identify cases in a timely fashion in order to interrupt the chain of infection through patient-level interventions such as management of sexual contacts and behavioral risk reduction counseling.

### B. Legal Reporting Requirements

1. Health care providers: notifiable to local health jurisdiction within 3 work days
2. Hospitals: notifiable to local health jurisdiction within 3 work days
3. Laboratories: notifiable to local health jurisdiction within 2 work days
4. Local health jurisdictions: notify the Washington State Department of Health (DOH), STD Services Section within 7 days of case investigation completion; summary information required within 21 days for all reported cases

### C. Local Health Jurisdiction Investigation Responsibilities

1. Gonorrhea cases should be reported using the STD Morbidity Report Form. Most Counties will report through the PHIMS-STD (<http://www.doh.wa.gov/LHJMap/LHJMap.htm>)
2. At a minimum, local health jurisdiction staff should initiate an investigation of the index patient within 3 working days of receiving a request for contact investigation from a reporting health care provider. Other cases should be investigated based on local priorities.
3. Local health jurisdiction staff should inform health care providers of the importance of instructing patients to refer sex partners for evaluation and treatment.

## 2. THE DISEASE AND ITS EPIDEMIOLOGY

### A. Etiologic Agent

*Neisseria gonorrhoeae*, bacterium.

### B. Description of Illness

Most infections in men produce symptoms of urethritis; the majority of women have no symptoms until complications have occurred. The complications of gonorrhea include epididymitis, proctitis, cervicitis, bartholinitis, pelvic inflammatory disease, pharyngitis

of adults, vulvovaginitis of children, conjunctivitis of the newborn, arthritis-dermatitis, endocarditis or meningitis.

### C. Gonorrhea in Washington State

DOH receives between 3,000 and 4,000 reports of gonorrhea per year, for an average rate of 59 per 100,000 population.

### D. Reservoir

Humans

### E. Mode of Transmission

Contact with exudates from mucous membranes of infected people, almost always as a result of sexual activity.

### F. Incubation Period

Usually 2-7 days; longer when symptoms occur.

### G. Period of Communicability

May extend for months in untreated individuals.

### H. Treatment

Current treatments include cefpodoxime, ceftriaxone, cefixime, ciprofloxacin. Because of increased resistance, quinolones should no longer be used in Washington State without a test of cure. Other treatment regimens are listed in STD Treatment Guidelines from CDC (<http://www.cdc.gov/std/treatment>).

## 3. CASE DEFINITIONS

### A. Clinical Criteria for Diagnosis

Infection with *Neisseria gonorrhoeae* is commonly manifested by urethritis, cervicitis, or salpingitis. However, the infection is often asymptomatic, particularly in women.

### B. Laboratory Criteria for Diagnosis

1. Isolation of typical gram-negative, oxidase-positive diplococci (presumptive *N. gonorrhoeae*) from a clinical specimen, or
2. Demonstration of *N. gonorrhoeae* in a clinical specimen by detection of antigen or nucleic acid, or
3. Observation of gram-negative intracellular diplococci in a urethral smear obtained from a male.

### C. Case Definition

1. Probable:
  - a. demonstration of gram-negative intracellular diplococci in an endocervical smear obtained from a female, or
  - b. a written morbidity report of gonorrhea submitted by a physician.
2. Confirmed: a case that is laboratory confirmed.

## 4. DIAGNOSIS AND LABORATORY SERVICES

### A. Diagnosis

Specimens for gonorrhea culture testing should be collected from the site suspected to be infected. Non culture tests (e.g. EIA, Direct fluorescent antibody, and nucleic acid amplification ) can be used for genital sites. Other sites such as nasopharynx, ophthalmic, neonatal testing and pneumonia require culture or consult with a laboratory specialist.

### B. Tests Available at PHL

Clinical specimens are analyzed for the presence of *N. gonorrhoeae* using the nucleic acid amplification test (NAAT) Aptima Combo II. This method allows for the detection of both *Chlamydia trachomatis* and *N. gonorrhoeae* from a single specimen. Initial positive results are confirmed by testing a second sample from the original specimen.

### C. Criteria for Testing at PHL

Specimens submitted for routine diagnostic purposes are generally from local health jurisdictions, STD clinics, family planning clinics, Planned Parenthood clinics and other clinics participating in Washington State's Infertility Prevention Project.

### D. Specimen Collection

See the Washington State laboratory web page for information on specimen mailing instructions: <http://www.doh.wa.gov/EHSPHL/PHL/packaging.htm>

## 5. ROUTINE CASE INVESTIGATION

### A. Evaluate the Diagnosis

All cases should be confirmed by a laboratory positive test (culture or nonculture tests such as nucleic acid amplification).

### B. Identify Source of Infection

To prevent reinfection, patients should be instructed not to have sex until all sex partners are treated. Routine case investigation methods will vary depending on whether the local health jurisdiction is participating in the Expedited Partner Treatment (EPT) program. The following case investigation method is to be used by local health jurisdictions participating in EPT:

1. Providers will indicate on the initial case report whether public health follow-up for partner management is needed or desired for their individual patients. Physicians and other diagnosing clinicians are expected to provide medication or prescriptions for medication, and partner management directions to their patients whenever possible. Exceptions are cases where the index case is unwilling to contact one or more exposed partners, where the patient is a man who has sex with men, or in cases where the clinician's best judgment is that the patient is not able or willing to follow through with partner contact.
2. For all patients referred to public health follow-up by providers and for cases selected for interview for evaluation purposes, a confidential partner management interview should be attempted. Local health jurisdictions may also establish priorities for public health follow-up such as pregnant females, residents at juvenile detention facilities or other

populations based on local priorities. Patient confidentiality must be preserved throughout the follow-up process. Telephone contact and interview is an acceptable methodology. Letters can be mailed to notify the patient that the LHJ is attempting to interview them. These letters should not have any information on the disease diagnosis to prevent breach of confidentiality if they are opened by someone other than the intended recipient. Partner management interviews will adhere to protocols established for the EPT project and will be entered into the PHIMS-STD data system. Case reports, laboratory results and patient interview and partner management information should be entered into the PHIMS-STD data system as soon as these data become available to local health jurisdiction staff. Local health jurisdiction staff may contact Washington State's STD Surveillance Coordinator (360 236-3441) for information on accessing and using the PHIMS-STD.

3. Through standard interviews with the patient, individuals who have had sexual contact with the case within 60 days prior to treatment should be identified. This should include both potential sources for the infection and other persons who the patient may have exposed. Local health jurisdiction staff should determine if the patient is willing and able to contact their partners and deliver partner treatment. If the patient is unwilling or unable to contact their partners, interviewers should obtain complete locating and identifying information on each contact, including nicknames and first and last dates of exposure. Each partner named should be reviewed with the patient during the interview to establish a follow-up method. The patient should also be encouraged to return to their provider to be re-screened for infection in 10 weeks.

### C. Managing Potentially Exposed Persons

All sex partners within 60 days before the onset of symptoms or diagnosis of infection in the patient should be evaluated, tested (if possible) and treated.

1. Using available information, the sexual partners of reported cases should be contacted within 2 working days of initial interview by telephone, field visit, or other method, and referred to their provider for evaluation, testing and treatment. If unable to obtain testing, patient can be referred to providers or a local participating pharmacy for treatment only. If the contact's treatment cannot be verified within a reasonable time frame, additional attempts should be made to assure treatment.
2. Sexual partners should be treated presumptively (EPT) for other common bacterial STDs (*C. trachomatis*), counseled, and evaluated for potential risk for HIV, syphilis and viral STDs such as HPV or genital herpes.
3. **Out-of-county contacts.** If the patient identifies a partner who lives outside of the local health jurisdiction (including out of state), the contact information may be transferred to the appropriate jurisdiction within PHIMS –STD. Or local health jurisdiction staff may provide the state STD Services Section (360 236-3460) with the relevant information to arrange for necessary follow-up.

### C. Documentation

1. There are two forms being used for STD interviews – the Integrated Partner Services Interview record, (brief and expanded versions available) and the Partner Management Record (CDC Interview Record). The CDC 2936 field record form can be used for

untreated persons or follow up of contacts.

2. The disposition (treatment outcome) of each partner must be recorded in PHIMS-STD or on the field record as soon as this information is available to local health jurisdiction staff.

#### **D. Environmental Evaluation**

Not applicable

### **6. CONTROLLING FURTHER SPREAD**

#### **A. Infection Control Recommendations**

1. Health care setting

Standard Precautions are a set of protocols designed to reduce the risk of (or prevent) transmission of pathogens. Standard precautions synthesize the major features of Universal (Blood and Body Fluid) Precautions (designed to reduce the risk of transmission of blood borne pathogens) and Body Substance Isolation (designed to reduce the risk of transmission of pathogens from moist body substances). Under standard precautions blood, all body fluids, and all body substances of patients are considered potentially infectious (CDC, 1997).

2. General

When used consistently and correctly, male latex condoms are effective in preventing the sexual transmission of STDs.

#### **B. Case Management**

See routine case investigation above.

#### **C. Contact Management**

See routine case investigation above.

#### **D. Management of Other Exposed Persons**

See routine case investigation above.

#### **E. Environmental Measures**

Not applicable

### **7. MANAGING SPECIAL SITUATIONS**

Call the Department of Health STD Services for special situations. (360-236-3460)

### **8. ROUTINE PREVENTION**

#### **A. Vaccine Recommendations**

No vaccine currently exists for gonorrhea.

**B. Prevention Recommendations**

Key individual STD prevention messages include:

**Abstinence**

Abstain from sex (do not have oral, anal, or vaginal sex) until you are in a relationship with only one person, are having sex with only each other, and each of you knows the other's STD, including HIV status.

**If you have, or plan to have, more than one sex partner:**

- Use a latex condom and lubricant every time you have sex.
- Get tested for asymptomatic STDs including HIV.
- If you are a man who has had sex with other men, get tested at least once a year.
- If you are a woman who is planning to get pregnant or who is pregnant, get tested for syphilis and HIV as soon as possible, before you have your baby. Ask your health care provider about being tested for other STDs.
- Talk about HIV and other STDs with each partner before you have sex.
- Learn as much as you can about each partner's past behavior (sex and drug use).
- Ask your partners if they have recently been treated for an STD or have been tested for HIV; encourage those who have not been tested to do so.
- Get vaccinated against hepatitis B virus.

**Do not inject illicit drugs.**

Drugs also affect your ability to make decisions, which may result in riskier sex.

**If you do inject drugs, do the following:**

- Use only clean needles, syringes, and other works.
- Never share needles, syringes, or other works.
- Be careful not to expose yourself to another person's blood.
- Get tested for HIV at least once a year.
- Consider getting counseling and treatment for your drug use.
- Get vaccinated against hepatitis A and B viruses.
- Do not have sex when you are taking drugs or drinking alcohol because being high can make you more likely to take risks.

Key prevention strategies include:

**STD prevention counseling, testing, and referral services** – Individuals at risk for STD should be offered counseling regarding methods to eliminate or reduce their risk and testing so that they can be aware of their status and take steps to protect their own health and that of their partners.

**Partner Services (or Partner Notification) with strong linkages to prevention and treatment/care services** – Sexual partners of STD-infected persons have been exposed to STD and are at-risk of being infected. Partner services locate these individuals based on information provided by the patient and provide counseling and education about the exposure as well as services to prevent infection or, if infected, linkages to care.

**Prevention for high-risk populations** – Prevention interventions for high-risk populations at high-risk for STDs, including HIV-infected persons, are critical to reducing the spread of STDs and HIV and ensure that those at highest risk of acquiring or transmitting these diseases are given the tools necessary to protect themselves and others from HIV infection. Prevention includes targeted health education and risk reduction, health communication programs, and public information programs for at-risk populations and the general public.

**School-based STD Prevention** – Schools have a critical role to play in promoting the health and safety of young people and helping them establish lifelong healthy behavior patterns. Washington State requires schools to teach medically accurate comprehensive sex education if such is provided by the school district.

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